Special Cases

Hospital Cases

When dental services are provided in an acute care general hospital or a surgicenter, you must document the need for hospitalization (e.g., retardation, physical limitations, age, etc.).

Hospital Inpatient Dental Services *(overnight or longer)*

Dentists who provide services for a Medi-Cal patient in a hospital setting are required to submit the Medi-Cal form 50-1 to Medi-Cal for authorization to admit the patient to the hospital. Do not send the 50-1 form to Denti-Cal, as this will delay authorization for hospital admission. Send the form 50-1 directly to:

Department of Health Services
San Francisco Medi-Cal Field Office
P. O. Box 3704
San Francisco, CA 94119

Hospital Outpatient Dental Services

For outpatient services, it is not necessary to obtain prior authorization for hospitalization from the Medi-Cal field office.

To request authorization to perform dental-related hospital services, providers need only submit a TAR, with x-rays and supporting documentation, directly to Denti-Cal.

Prior authorization is required only for the following services: crowns, root canal treatment, prosthetics, and periodontal treatment. It is not necessary to request authorization for services that do not ordinarily require prior authorization, even if they are provided in an outpatient hospital setting. However, an operating room report or hospital discharge summary will still be required when submitting claims for payment.

Services that require prior authorization may be performed on an emergency basis; however, you must document the reasons for the emergency services. Enclose a copy of the operating room report, and indicate the amount of time spent in the operating room suite.

When submitting a claim for payment for non-emergency services, attach a copy of the operating room report and indicate the amount of time spent in the operation room suite.

Homebound Patients

Providers are required to submit a letter from the patient's physician when requesting treatment for a patient who cannot leave his or her private residence for dental treatment due to a medical condition. The physician's letter must be on professional letterhead or a prescription form, and the following information must be documented:

- The patient's specific medical condition
- The reason the patient cannot leave the private residence
- The length of time the patient will be homebound

Orthodontic Services for Handicapping Malocclusion

California Medi-Cal Dental Program benefits include medically necessary orthodontic services. These benefits are available to eligible individuals with handicapping malocclusion who are under 21 years of age. Regulations governing the provision of these program benefits are listed in the Manual of Criteria for Medi-Cal Authorization (Dental Services), included in Section 4 of this manual. A fee schedule listing the valid procedures under this program and the appropriate reimbursement rates is also included in the Manual of Criteria.

Denti-Cal has created a manual for orthodontists who are certified to participate in the Denti-Cal Orthodontic Services for Handicapping Malocclusion Program. This manual contains the policies, guidelines and procedures outlined in this section, as well as additional information to help orthodontists provide services under this specialized Denti-Cal program. If you are a certified orthodontist and would like a copy of this manual, send your request to:

Denti-Cal
California Medi-Cal Dental Program
Printing and Publications Unit
P.O. Box 15609
Sacramento, CA 95852-0609

Orthodontic services available under this program are limited to only those that meet the general policies and requirements for handicapping malocclusion, set forth in Title 22,

Sections 5l003(e), 51307 and 51506.2. Eligibility for these services ends when the patient reaches age 21, with no extended service period allowed.

Qualified orthodontists may submit claims for reimbursement of orthodontic services provided to eligible Medi-Cal beneficiaries. Title 22, Section 51223(c) defines a "qualified orthodontist" as a dentist who "confines his practice to the specialty of orthodontics" and who either "has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association" or "has completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontists."

Prior to initiating the Treatment Authorization Request for the provision of orthodontic services under the handicapping malocclusion program, orthodontists must submit a completed Handicapping Labio-Lingual Deviation (HLD) Index score sheet that documents the medical necessity of the orthodontic services. An example of the HLD Index and instructions on how to complete the form are shown in the Manual of Criteria in Section 4 of this manual. Denti-Cal will furnish an initial supply of HLD score sheets to providers upon certification approval. Additional HLD score sheets (form DC016) may be obtained through the Denti-Cal forms supplier by checking the appropriate box on the Denti-Cal Forms Reorder Request.

When completing the HLD Index, please remember that it must meet all documentation requirements to be considered complete. For example, in instances of severe traumatic deviation, please document on the HLD Index the nature of the traumatic deviation.

Following are Orthodontic Services for Handicapping Malocclusion Program instructions, including enrollment and certification procedures, submission requirements, billing instructions and processing tips.

Enrollment and Orthodontic Certification

1. You must be an enrolled Denti-Cal provider to qualify for participation in this new program. An orthodontist who wishes to submit claims for services provided to eligible Medi-Cal dental beneficiaries must first complete an Orthodontia Provider Certification form. For an enrollment application and information, please call Denti-Cal at (800) 423-0507.
2. Complete the Orthodontia Provider Certification form and return it promptly to Denti-Cal. Denti-Cal will enter an appropriate code on your automated provider records to establish and identify you as a provider of services under the Orthodontic services for Handicapping Malocclusion program.
3. Denti-Cal will notify you in writing when the certification has been approved.

Every certified orthodontist must be listed with Denti-Cal as a rendering provider in each service office in which he or she treats patients. It is the responsibility of the certified orthodontist to make sure that he/she is authorized by Denti-Cal to provide treatment in a particular service office.

Preliminary and Comprehensive Diagnostic Examinations and Treatment Plan Authorization

1. Conduct the initial examination and complete the HLD Index according to the instructions on the back of the form to assess the degree of handicapping malocclusion.

   Completion of the initial orthodontic examination, which includes the HLD Index, does not require prior authorization (all other orthodontic services, including study models and the diagnostic workup, require prior authorization).
2. Submit a Denti-Cal Claim form for payment of Procedure 551, Initial Orthodontic Exam, indicating the date of service. Denti-Cal will process the payment of Procedure 551.
3. If the patient qualifies for orthodontic benefits based on the HLD Index, a Treatment Authorization Request (TAR) for the study models (Procedure 558) should be submitted at the same time as the claim for payment of Procedure 551. The TAR must be accompanied by the completed HLD Index form showing a minimum score of 26 points to qualify for

authorization. Remember to include the HLD Index with the authorization request for Procedure 558 to help avoid unnecessary delays in processing your treatment plan authorization. Orthodontists should not submit a TAR for Procedure 558 for patients with mixed dentition under the age of 13. These patients do not qualify for orthodontic benefits under the Denti-Cal program. Denti-Cal will, however, consider orthodontic treatment for patients with mixed dentition who are 13 years of age or older.

4. Denti-Cal will evaluate the TAR submitted and will generate a Resubmission Turnaround Document (RTD) if a TAR for Procedure 558 is submitted but no HLD Index is included; or approve the TAR for Procedure 558 if the HLD Index included shows a minimum score of 26 points.

   Please note that Denti-Cal will not retain the hard copy of the HLD index for Procedure 558 (study models), regardless of whether the study models are approved or disallowed. If the request for Procedure 558 is disallowed, the provider will be required to submit a new HLD index.

Treatment Plan Authorization and Payment Submission Procedures

1. Upon receipt of the Notice of Authorization (NOA) for Procedure 558, make the study models. Submit the NOA with date(s) of service along with the study models as documentation for payment. Denti-Cal will process the NOA for payment of Procedure 558.

   Please note that payment of Procedure 558 can be made only when accompanied by your diagnostic study models. Many providers choose to satisfy this requirement by submitting for payment of Procedure 558 at the same time they submit the study models with their request for Procedure 557 (Diagnostic Workup) and treatment.

2. Attach a new TAR for the proposed plan of treatment when submitting the NOA for payment of Procedure 558. Be sure to indicate in the "Quantity" field of the TAR form the number of visits for active treatment and/or the number of subsequent quarterly follow-up observations required for treatment. Study models must be submitted as documentation for payment of diagnostic Procedure 558 and to substantiate treatment plans for Procedures 557, 552, 554, 599 and 556, using the following guidelines:

   a. Please submit disposable rough-trimmed, second-pour or duplicate study models. These study models will not be returned to you unless Denti-Cal receives your written request at the time of the submission of the NOA and TAR, and then only those study models of approved cases will be returned.

   b. The submitted study models must be sufficiently trimmed to allow placement into centric occlusion. Models that do not allow this (e.g., untrimmed) will be returned to your office as unusable. Additionally, a bite registration (wax, etc.) or the marking of occlusion on the models must be included to meet the criteria for acceptable study models.

   c. To facilitate an evaluation, be sure to mark centric on the study models. In cases of open bite, it would be helpful to include a wax bite to assist Denti-Cal in determining the patient's needs.

   d. Study models should be clearly labeled with proper identification so they can be matched with the correct Treatment Authorization Request. This identification should clearly indicate the patient's name, Social Security number or Medi-Cal identification number, and the dentist's name. If any of this information is not marked on the study model, Denti-Cal will attempt to identify the patient on our automated system. However, if the study model does not contain sufficient information to properly identify it, Denti-Cal will destroy it.

   e. Careful packaging of study models and bite registration will help ensure they arrive at Denti-Cal in good condition. We receive many broken and damaged study models due to poor packaging; this means that they must be returned to the orthodontist for re-

submission, which causes processing delays and unnecessary duplication of study models. Use a box that has sufficient packaging material (such as styrofoam "peanuts," shredded newspaper, "bubble wrap," etc.) so that study models will not be jarred or bumped during shipping. Also, be sure to place some packaging material between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

f. Please do not mail the study models in the same envelope or mailing container as the NOA and TAR. Send the NOA and TAR together to Denti-Cal in the blue-bordered mailing envelope. Study models should be packaged separately for mailing to Denti-Cal at the same time as the NOA and TAR.

g. Study models are required documentation for all orthodontic treatment plan requests except in cleft palate cases. For cleft palate cases that are not managed or authorized by California Children's Services (CCS), narrative documentation is adequate for Denti-Cal authorization.

h. Approved study models will be destroyed by Denti-Cal after five working days. A letter will be sent to the provider for study models that have been stored at Denti-Cal over 30 days pending receipt of a Treatment Authorization Request (TAR). If a TAR is not received within 30 days of the letter, the study models will be destroyed.

In addition to study models, you may also be required to submit head films and photographs if deemed necessary by Denti-Cal orthodontic consultants. Denti-Cal does not require that providers attach an HLD index when submitting a TAR for Procedures 552, 554, 556, 557 and 599.

3. When the new TAR is authorized by Denti-Cal, you will receive a series of Notices of Authorization confirming authorization. Notices of Authorization will be sent to you at the beginning of your authorization date and every three months thereafter throughout the treatment plan authorization period. These Notices of Authorization should be used for monthly billing purposes.

4. Each month when services are provided, submit one Notice of Authorization to Denti-Cal for payment. Be sure to indicate the date of service and sign the Notice of Authorization before submitting the Notice of Authorization to Denti-Cal.

5. Under the Denti-Cal orthodontic program, confirmation of continued treatment is required. At the end of each 12 months of treatment authorization, you will receive a Resubmission Turnaround Document requesting your signature to confirm continued treatment for the subsequent 12 months or remaining balance. If your patient's orthodontic treatment will continue beyond 12 months, you must indicate your intent to continue treatment by signing the Resubmission Turnaround Document.

6. Notices of Authorization for payment will be processed in accordance with general Denti-Cal billing policies and criteria requirements for Orthodontic Services for Handicapping Malocclusion. Please remember that authorization does not guarantee payment. PAYMENT IS SUBJECT TO PATIENT ELIGIBILITY.

To help facilitate your participation in our Orthodontic Services for Handicapping Mal occlusion Program, we suggest you follow these guidelines in addition to the above program instructions. We have also included a list of the codes and corresponding messages which will appear on various documents that Denti-Cal processes for you under the Orthodontic Services for Handicapping Malocclusion Program.

Eligibility

- Patient eligibility must be current and must cover orthodontic benefits.
- If a patient transfers from one certified Denti-Cal orthodontist to another certified Denti-Cal orthodontist, prior authorization is necessary before continuing treatment.
- Transfer of a case in progress by another carrier requires prior authorization. Original study models, plus new study models and other documentation, must be submit-

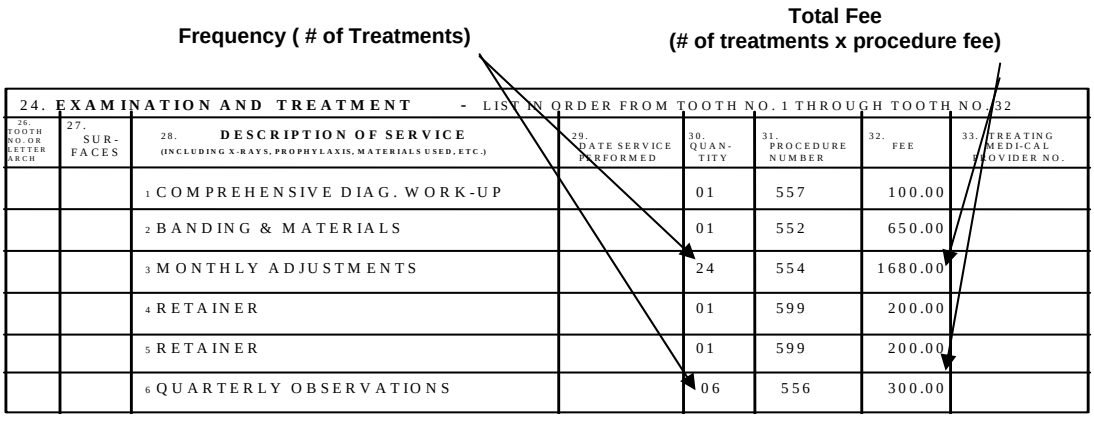
ted to validate benefits under Denti-Cal's orthodontic program.

Benefits

- Orthodontic benefits under the Denti-Cal program are limited to those specific to handicapping malocclusion. The Denti-Cal scope of benefits does not cover all orthodontic-related services.
- Orthodontic treatment is for permanent dentition except in cleft palate cases that are authorized and managed by CCS. Note: Primary teeth with no permanent successors are considered permanent dentition.
- In deep impinging overbite, the lower incisors must be destroying the soft tissue of the palate. Contact only does not constitute deep impinging overbite under the Orthodontic Services for Handicapping Malocclusion Program.
- For crossbite of individual anterior teeth to qualify as a condition of handicapping malocclusion, there must be evidence of soft tissue destruction (e.g., stripping of the labial gingival tissue on the lower incisors).
- Bi-lateral crossbite is not a benefit of the Orthodontics for Handicapping Malocclusion Program.
- Replacement retainers are a one-time only benefit unless documentation identifies an unusual situation requiring an additional replacement.
- Extraction of asymptomatic teeth is not a benefit. However, extractions that are required to complete medically necessary orthodontic dental services may be considered symptomatic when documented.

Document Processing

- The original Treatment Authorization Request (TAR) form submitted for Procedures 554 and 556 must list the frequency (number of treatments) in the "Quantity" column (item #30) and the total fee (fee for the procedure times the number of treatments) in the "Fee" column #32. The example above shows the correct way to list these procedures to ensure accurate calculation of the Notice of Authorization.



24. **EXAMINATION AND TREATMENT** - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

26. TOOTH NO. OR LETTER ARCH	27. SUR-FACES	28. **DESCRIPTION OF SERVICE** (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUAN-TITY	31. PROCEDURE NUMBER	32. FEE	33. TREATING MEDI-CAL PROVIDER NO.
		1 COMPREHENSIVE DIAG. WORK-UP		01	557	100.00	
		2 BANDING & MATERIALS		01	552	650.00	
		3 MONTHLY ADJUSTMENTS		24	554	1680.00	
		4 RETAINER		01	599	200.00	
		5 RETAINER		01	599	200.00	
		6 QUARTERLY OBSERVATIONS		06	556	300.00	

Medicare/Medi-Cal Crossover Claims

Medicare will pay for certain dental services identified in the Medicare/Medi-Cal Crossover Procedure Codes and Descriptions.

If item 31 on a claim or TAR submitted for a Medi-Cal dental patient lists any of the procedure codes in the Medicare/Medi-Cal Crossover Procedure Codes and Descriptions shown in this section, the claim or TAR must be accompanied by official documentation which clearly shows proof of payment/denial by Medicare or states the patient's ineligibility. Documentation of ineligibility may be:

1. an Explanation of Medicare Benefits (EOMB) stating "No Part B coverage";
2. an EOMB stating "Benefits are exhausted";
3. an official document verifying the patient's alien status;
4. an EOMB or any official document from the Social Security Administration verifying patient's ineligibility for Medicare.

Denti-Cal processes claims and TARs for Medicare covered dental services in accordance with the following Medicare/Medi-Cal crossover policies and procedures:

1. A provider must be enrolled with Medicare to bill Denti-Cal for Medicare/Medi-Cal crossover services.
2. Before a claim can be submitted to Denti-Cal for payment of Medicare covered services, Medicare must be billed.
3. Approved and paid Medicare dental services do not require prior authorization by Denti-Cal.
4. Payment for a Medicare covered dental service does not depend on place of service; hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of any given dental procedure.
5. For information about Medicare enrollment and billing procedures, you may contact your local Medicare field office.

Northern California
Medicare Provider Certification
P.O. Box 2812
Chico, CA 95927-2812
(530) 743-1587

Southern California
National Heritage Insurance Company
Medicare Administration
Certification Department
P.O. Box 60560
Los Angeles, CA 90060-0560
(213) 742-3996 or
(866) 502-9054 (toll-free)

When processing a claim with Medicare covered services, Denti-Cal reviews the EOMB submitted with the claim. The Medicare procedures listed on the EOMB are matched with the Medi-Cal dental procedures listed on the claim. Payment calculations are based on Medicare deductibles, coinsurance and Medi-Cal allowable amounts up to the Schedule of Maximum Allowances.

Medicare/Medi-Cal Crossover

Procedure Codes & Descriptions

Procedure Code	CPT 4 Codes	ADA	Narrative Description
150	11100	07285	Biopsy of Oral Tissue
		07286	
160	88302	00501	Gross and Microscopic
	88304	00502	"Histopathologic Examination"
269	11440	07430	Excision of Benign Tumor, up to 1.25 cm
	11441		
270	11442 thru 11446	07431	Excision of Benign Tumor, Larger than 1.25cm
277	21045	07490	Radical Resection of Bone for Tumor with Bone Graft
	21215		
285	21050	07840	Condylectomy of Mandible, Unilateral
281	21030	07450, 07451	Excision of Cyst Over 1.25 cm
	21040 or 21041	07460, 07461	
289	21060	07850	Meniscectomy of Temporomandibular Joint, Unilateral
295	64600	N/A	Injection of Trigeminal Nerve Branches for Destruction
900	21422	07710	Maxilla, Open Reduction, Simple
901	21421	07720	Maxilla, Closed Reduction, Simple
902	21462	07730	Mandible, Open Reduction, Simple
903	21451	07740	Mandible, Closed Reduction, Simple
905	21422	07710	Maxilla, Open Reduction, Compound
904	21421	07720	Maxilla, Closed Reduction, Compound
906	21451	07740	Mandible, Closed Reduction, Compound
907	21462	07730	Mandible, Open Reduction, Compound
913	21480	07820	Reduction of Dislocation of Temporomandibular Joint
915	21355	07760	Treatment of Malar Fracture, Simple, Closed Reduction
916	21360 or 21365	07750	Treatment of Malar Fracture, or Simple or Compound Depressed, Open Reduction
970-976	21079 thru 21089	05931 thru 05999	Maxillofacial Prosthetic Reconstruction
985	21499 or 21120 thru 21299	07920 thru 07999	Surgical Services (Maxillofacial surgical or services are a benefit for the anatomic and functional reconstruction of those structures missing, defective, or deformed because surgical intervention, trauma pathology or developmental or congenital malformations. Cosmetic or aesthetic enhancement may result from such surgical services but cannot be the primary motivation for surgical services.)

* Excision of benign cyst or tumor is not indicated by size, but rather by simple or complex procedure.